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Practices and challenges in the care provided to hospitalized patients with wounds in an Emergency Care Unit**

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ABSTRACT

Objective: To understand the care provided by nurses to patients with wounds who, while hospitalized in an Emergency Care Unit (UPA), await transfer to a referral hospital. **Methods:** This was a qualitative, exploratory, and descriptive study conducted in a virtual environment between February and March 2025 with nurses working in a UPA. Data collection was carried out through semi-structured interviews, and data analysis was performed using the Collective Subject Discourse method. **Results:** Thirteen nurses participated in the study, most of whom were female, with a mean age of 41 years, 15.9 years of professional experience, and 6 years of experience in the sector. Care provided to patients with wounds hospitalized in the UPA was characterized as a complex and challenging phenomenon influenced by multiple factors — overcrowding, prolonged patient stays, increased demands, nurses' workload burden, provision of care without adequate supervision, gaps in professional training, and noncompliance with current legislation — all of which directly compromise the quality and safety of the care provided. **Conclusion:** The prolonged stay of patients in UPAs changes the care profile and poses challenges to nursing care for individuals with hard-to-heal wounds, within a context of work overload and structural limitations.

KEYWORDS: Wounds and injuries. Emergency nursing. Emergency service, hospital. Healthcare work process. Stomatherapy.

Práticas e desafios na assistência à pessoa com ferida internada na Unidade de Pronto Atendimento

RESUMO

Objetivo: Compreender a assistência prestada pelo enfermeiro à pessoa com ferida que, internada em Unidade de Pronto Atendimento (UPA), aguarda transferência para hospital de referência. **Métodos:** Trata-se de uma pesquisa qualitativa, de caráter exploratório e descritivo, realizada em ambiente virtual entre os meses de fevereiro e março de 2025, com enfermeiros de uma UPA. A coleta de dados foi conduzida por meio de entrevistas semiestruturadas, e a análise por meio do Discurso do Sujeito Coletivo. **Resultados:** Participaram do estudo 13 enfermeiros, sendo a maioria do sexo feminino, com média de 41 anos de idade, 15,9 anos de

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formação profissional e 6 anos de atuação no setor. A assistência à pessoa com ferida internada na UPA configurou-se como um fenômeno complexo e desafiador, influenciado por múltiplos fatores — superlotação, permanência prolongada dos pacientes, intensificação das demandas, sobrecarga do enfermeiro, realização de cuidados sem supervisão adequada, lacunas na capacitação profissional e descumprimento da legislação vigente —, os quais comprometem diretamente a qualidade e a segurança do cuidado oferecido. **Conclusão:** A permanência prolongada de usuários nas UPAs modifica o perfil assistencial e impõe desafios ao cuidado de enfermagem às pessoas com feridas de difícil cicatrização, em contexto de sobrecarga e limitações estruturais.

DESCRITORES: Ferimentos e lesões. Enfermagem em emergência. Serviço hospitalar de emergência. Processo de trabalho em saúde. Estomaterapia.

Prácticas y desafíos en la atención a la persona con heridas hospitalizada en la Unidad de Atención de Emergencia**

RESUMEN

Objetivo: Comprender la atención prestada por el enfermero a la persona con heridas que, hospitalizada en una Unidad de Atención de Emergencia (UPA), espera transferencia a un hospital de referencia. **Métodos:** Se trata de una investigación cualitativa, de carácter exploratorio y descriptivo, realizada en un entorno virtual entre los meses de febrero y marzo de 2025, con enfermeros de una UPA. La recolección de datos fue conducida mediante entrevistas semiestructuradas y el análisis mediante el Discurso del Sujeto Colectivo. **Resultados:** Participaron en el estudio 13 enfermeros, siendo la mayoría del sexo femenino, con una media de 41 años de edad, 15,9 años de formación profesional y 6 años de actuación en el sector. La atención a la persona con heridas hospitalizada en la UPA se configuró como un fenómeno complejo y desafiante, influenciado por múltiples factores —saturación de los servicios, permanencia prolongada de los pacientes, intensificación de las demandas, sobrecarga del enfermero, realización de cuidados sin supervisión adecuada, lagunas en la capacitación profesional e incumplimiento de la legislación vigente—, los cuales comprometen directamente la calidad y la seguridad del cuidado ofrecido. **Conclusión:** La permanencia prolongada de usuarios en las UPAs modifica el perfil asistencial e impone desafíos al cuidado de enfermería de las personas con heridas de difícil cicatrización, en un contexto de sobrecarga y limitaciones estructurales.

DESCRIPTORES: Heridas y lesiones. Enfermería de urgencia. Servicio de urgencia en hospital. Proceso de trabajo en salud. Estomaterapia.

INTRODUCTION

The Emergency Care Units (UPAs) were established by Ordinance No. 1,020, dated May 13, 2009, and are part of the National Emergency Care Policy instituted by the Brazilian Ministry of Health in 2003 through Ordinance No. 1,863. These units comprise the intermediate level between primary and hospital care and are responsible for the management of acute conditions and the clinical stabilization of patients requiring immediate assessment. They are classified into types I, II, and III according to population coverage and installed capacity, serving areas ranging from 50,000 to 300,000 inhabitants. It is estimated that they provide between 150 and 350 consultations daily, depending on the size of the unit[1,2].

According to regulatory parameters, the maximum length of stay for a patient in an Emergency Care Unit (UPA) is 24 hours. During this period, the multidisciplinary team is expected to perform clinical assessment, initiate therapeutic interventions, and determine whether the patient should be discharged or transferred to a hospital facility. However, the reality of healthcare services often differs from these recommendations, and prolonged stays among

patients awaiting hospital admission are common[3]. This situation has led UPAs to provide care for patients with greater clinical complexity and ongoing healthcare needs, thereby assuming, in practice, care functions typically associated with inpatient hospital units.

A study conducted by Regio[3] identified a mean length of stay of 3.16 days in adult and pediatric observation sectors and stabilization rooms, with variation ranging from 2 to 12 days across sectors. Among the recorded diagnoses, 7.71% of patients presented diseases of the skin and subcutaneous tissue. These findings indicate that, although UPAs were originally designed for short-term care, they frequently assume healthcare functions similar to those of inpatient units, providing follow-up care for patients with complex clinical conditions[4].

The perceived low resolutive capacity of primary healthcare, combined with the search for immediate care, has contributed to increased demand in UPAs[5]. This scenario results in overcrowding and excessive workload within these units, exceeding the care limits established by Ordinance No. 1,601/2011[2]. Consequently, an intensification of nursing work and a negative impact on the quality of care have been observed.

In Brazil, there are no consolidated epidemiological data accurately estimating the prevalence of hard-to-heal wounds. Nevertheless, it is estimated that approximately 570,000 Brazilians develop this condition annually, with prevalence reaching up to 20 cases per 100,000 inhabitants among individuals older than 80 years[6]. In a study involving older adults monitored in primary healthcare settings, the prevalence of chronic wounds was 8% (95% CI 5.0–10.9), with pressure injuries (5%), diabetic ulcers (3.2%), and vasculogenic ulcers (2.9%) being the most frequent[7]. These lesions are characterized by prolonged progression and high therapeutic complexity, often associated with chronic diseases and clinical conditions that impair the healing process[8].

In this context, UPAs have increasingly provided care for patients with complex clinical conditions, including individuals with hard-to-heal wounds, whose management requires systematic clinical assessment and continuous care[4]. A substantial proportion of hospitalizations in UPAs is related to long-standing skin lesions with slow and unfavorable healing processes, which frequently progress to complications requiring inpatient care[9]. The management of these lesions in emergency care settings imposes additional challenges on healthcare teams, demanding careful clinical assessment, establishment of therapeutic strategies, and monitoring of wound progression[8].

Wound care requires systematic clinical assessment by nurses in order to ensure qualified care and individualized management according to the characteristics of each lesion[10]. Resolution No. 567/2018 of the Brazilian Federal Nursing Council[11] regulates nursing practice in this field, assigning nurses responsibility for wound assessment, prescription, and dressing procedures, in addition to coordinating and supervising the nursing team. Nursing technicians may perform dressing procedures under the prescription and supervision of a nurse.

The assignment of dressing procedures to nursing technicians is permitted provided that the nurse performs prior clinical assessment and prescribes the appropriate care. It is important to emphasize that this practice does not exempt the nurse from legal and ethical responsibility for the procedure, making them jointly responsible for care outcomes[12].

Despite the high healthcare demand in UPAs and the frequent presence of patients with skin lesions, studies systematically describing how nursing care for individuals with wounds is organized in this context remain scarce. This gap is particularly relevant given the clinical complexity of these patients and the care demands imposed by wound management in emergency care settings.

In this scenario, it becomes necessary to understand how nursing care for hospitalized patients with wounds is configured within UPAs. Therefore, this study seeks to answer the following research question: how is the care provided by nurses to hospitalized patients with wounds in UPAs configured? Understanding this practice may contribute to improving the nursing work process and enhancing the quality of care provided to individuals with wounds at this level of healthcare.

OBJECTIVES

To understand the care provided by nurses to individuals with wounds who are hospitalized in an Emergency Care Unit (UPA) while awaiting transfer to a referral hospital.

METHODS

This is a qualitative, exploratory, and descriptive study guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ), conducted in a type III Emergency Care Unit (UPA) located in the countryside of the state of Minas Gerais, Brazil, providing healthcare coverage to 13 municipalities within the microregion.

The study population consisted of nurses providing direct patient care during daytime shifts — the period in which dressing procedures are predominantly performed — and who had at least six months of experience in the investigated unit. Professionals who were on leave due to medical leave exceeding 15 days, extended vacation leave, unpaid leave, or maternity leave during the data collection period were excluded from the sample. Participants were selected through purposive sampling, considering professionals who met the established eligibility criteria.

The number of participants was determined according to the criterion of theoretical saturation, reached when the interviews began to show repetition of content and no emergence of new elements relevant to the investigated phenomenon. A total of 13 nurses participated in the study.

To characterize the participants, sociodemographic and professional information was collected, including sex, age, year of graduation in nursing, completion of postgraduate education, and length of professional experience in the investigated unit. These data were obtained through a structured form administered prior to the interview, containing questions regarding the participants' personal characteristics and professional background.

Data collection was conducted by a researcher external to the service, with no professional affiliation to the investigated unit, who had been previously trained in conducting qualitative interviews.

The semi-structured interviews were conducted individually in a private virtual environment through the Google Meet platform, ensuring privacy and confidentiality during participation. Audio recordings were made using the platform's recording application for subsequent full transcription of the material. No automatic transcription tool was used, and the audio recordings were manually transcribed by the researchers.

A semi-structured interview guide composed of open-ended questions was used to ensure coverage of all aspects relevant to the study object while encouraging participants to freely express their perceptions. The guide consisted of six guiding questions aimed at understanding the nurses' work process in the UPA and the care provided to patients with lesions or wounds.

The questions addressed:

1. The work process within the unit;
2. Care provided to patients awaiting hospital transfer;
3. Care delivered to patients with lesions or wounds;
4. Performance of dressing procedures by healthcare professionals;
5. Monitoring of lesion progression; and
6. Availability of materials and dressings for wound care procedures.

The interviews were conducted between February and March 2025, with an average duration of 20 minutes, varying according to participant availability and the depth of their responses. After transcription, the records were checked against the original audio recordings to ensure fidelity to the interview content.

Data analysis was based on the Collective Subject Discourse (CSD) methodology, as proposed by Lefèvre13, and was conducted in two stages. The first stage consisted of five steps:

1. Individual analysis of responses for each question, applying the Collective Subject Discourse (CSD) technique;
2. Identification and highlighting of Key Expressions (KEs), understood as excerpts representative of the essence of the participants' discourse;
3. Extraction of Central Ideas (CIs), corresponding to the meanings contained in the KEs;
4. Grouping of the CIs according to similarity or complementarity of meaning; and
5. Formulation of a representative CI for each identified group.

In the second stage, two additional steps were performed:

1. Construction of a new analytical form, termed Discourse Analysis Instrument 2, corresponding to each group of CIs; and

2. Development of the Collective Subject Discourses themselves, written in the first-person singular in order to give voice to the collective, according to the methodological principles proposed by Lefèvre[13].

The analysis was conducted independently by two researchers, followed by discussion and consensus to define the central ideas and construct the Collective Subject Discourses.

All ethical principles governing research involving human subjects were strictly observed. This study was approved by the Research Ethics Committee of the Federal University of Minas Gerais under CAAE number: 85687924.9.0000.5149. Participation of the professionals was voluntary and formalized through the signing of the Informed Consent Form (ICF).

RESULTS

A total of 13 nurses participated in the study, the majority of whom were female (n=11). Participants' ages ranged from 29 to 52 years, with a mean age of 41 years. Length of professional training ranged from 7 to 23 years (mean of 15.9 years), while length of experience working in the UPA varied from 7 months to 11 years, with a mean of 6 years.

After transcription, the interview content was analyzed by extracting the KEs, that is, the most significant excerpts. For each key expression, the corresponding CI was identified to synthesize the discursive content expressed in the KEs. Based on the CIs, synthesis discourses were constructed in the first-person singular, constituting the Collective Subject Discourses (CSDs), in which the perspective of a group or collective can be presented as an individual discourse.

At the end of each discourse, the participants whose KEs contributed to the formulation of the respective CSD were identified using an alphanumeric code. Each interviewee was designated by the letter "E" followed by an Arabic numeral from 1 to 13, according to the order in which the interviews were conducted.

CI 1 reveals an emerging configuration within the context of Emergency Care Units (UPAs): the prolonged stay of hospitalized patients, in contrast to the service's original purpose. This extended stay results from weaknesses in the coordination and resolutive capacity of the Healthcare Network (RAS), which hinder patient referral within the recommended 24-hour period.

CI 1 – The Reality of the UPA

> CSD: "*The UPA is an urgent and emergency care service with open access, and theoretically it should not function as a scheduled service with hospitalized patients, since they should be referred to the referral hospital*" (E4, E5, E6, E8, E10, E13).

The UPA, originally designed for acute and short-term care, does not have adequate physical infrastructure or sufficient human resources, either in number or qualification, to meet the demands arising from the prolonged stay of hospitalized patients. This mismatch directly compromises patient safety and the quality of nursing care provided within the unit.

CI 2 – Hospitalized Patients

> CSD: "*There are hospitalized patients in sectors such as the medication and observation units, where I admit patients who are hospitalized, almost as if it were an inpatient ward. They remain awaiting transfer to the municipal hospital and, in surgical cases, to the [name of the institution] hospital for two, sometimes three or more days, because the referral bed is still unavailable. At the peak of its overload, the UPA had around 70 hospitalized patients. We remain expecting a transfer, but often the patients are not transferred at all. What, in my view, most affects the quality of care is the length of time patients remain in the UPA and the delay in being transferred. In addition, the number of beds here is insufficient for the demand, because all patients are awaiting transfer*" (E1, E2, E3, E4, E5, E8, E9, E10, E12, E13).

Care provided to hospitalized and clinically stabilized patients is generally carried out by mid-level nursing staff, while nurses are called upon only in situations involving doubts, complications, or circumstances requiring more complex decision-making.

CI 3 – Wound Assessment

> CSD: "*The team performs the initial approach. When the nursing technicians provide bed bathing and identify a wound, they come and inform me. When they perceive a certain level of severity, they request an evaluation by the nurse responsible for the sector. If the technical staff calls me because they have doubts, I am able to provide closer follow-up and assess the situation according to my technical knowledge*" (E1, E2, E3, E4, E5, E6, E8, E9, E10, E12).

When dressing procedures are required, the performance of this care is often delegated to nursing technicians, frequently without the direct supervision of a nurse and, in many cases, without prior clinical assessment of the lesion by the nurse.

CI 4 – Performance of Dressing Procedures

> CSD: "*Usually, it is the nursing technician who performs the dressing procedure, except for central line dressings, which are performed by the nurse. The nursing technicians carry out the procedures on their own, based on their experience, since many of them have years of professional training. The nurse does not always perform the assessment. I am not always able to perform the dressing myself, for example. To be very honest, dressings for many wounds are performed by the nursing technician; in other words, the nursing technicians are the ones carrying out the procedures. When any doubts arise, I always provide guidance, but the procedure remains primarily the responsibility of the nursing technician. If I am unable to perform it at that moment, I provide instructions on how to do it properly, and the technicians are advised to seek the nurse so the dressing can be performed together with them. I do provide follow-up; however, the procedure itself is performed by the nursing technician*" (E1, E3, E5, E6, E9, E11, E12, E13).

The workload experienced by nurses in the UPA is substantial, requiring them to establish priorities in the face of multiple care demands. The work process, characterized by high complexity and limited resources, compels nurses to determine which care activities will be performed directly by them and which will be delegated to mid-level nursing staff.

CI 5 – Impracticability of Nurses Performing Dressing Procedures

> CSD: "*There are times when I am responsible for monitoring 50 hospitalized patients with an understaffed team, and I simply cannot stop to perform a dressing procedure. Realistically, I am unable to do so because the demand in the Emergency Care Unit is enormous, you know? At the emergency care level, in the UPA, I just cannot manage it. In addition, monitoring wound progression is very difficult because patient turnover is extremely high. Therefore, I am unable to follow the lesion over time due to both the high turnover and the limited time available*" (E1, E3, E4, E5, E6, E7, E9, E12).

Furthermore, the need for continuous training of the entire nursing team is evident, especially for nurses, regarding the clinical assessment of wounds and the appropriate selection of dressings and wound care techniques, in order to improve the quality of care provided and promote patient safety.

CI 6 – Continuing Health Education

> CSD: "*I feel outdated and, because I work in an area that does not use dressings and wound coverings very often, my knowledge becomes more limited, you know? But it is precisely due to the lack of training that I do not even know what to*

use in certain situations, because we have never had wound care training. Actually, we did have one session, but the lack of ongoing training and the limited recognition of the importance of wound care within the UPA make these practices become largely neglected there. There should be a continuing education center here so we could know the appropriate way to treat each wound. We do have some knowledge about dressings, but it comes only from undergraduate education and remains very superficial" (E4, E6).

DISCUSSION

Care for hospitalized patients requires rigorous monitoring, including continuous assessments and readiness of the healthcare team to manage any complications that may arise during the patient's stay[14]. In this context, nursing plays a central role in the UPA by maintaining constant surveillance, providing uninterrupted care, and promptly identifying clinical changes and signs of hemodynamic instability[15].

To provide high-quality care, it is essential to apply the Nursing Process (NP), which consists of the stages of assessment, nursing diagnosis, planning, implementation, and evaluation, all of which should systematically guide the care provided to patients in UPAs, including those with hard-to-heal wounds[16].

However, the NP has not been fully implemented in the care of patients with wounds. Evidence indicates that the stages of the process are documented in a fragmented manner, with a predominance of generic prescriptions and the absence of well-founded nursing diagnoses and individualized care planning[17,18]. This scenario is concerning, considering that responsibility for dressing procedures is a professional prerogative of nurses and should be grounded in clinical judgment that takes into account the severity and complexity of the lesion[19].

Therefore, careful wound assessment by nurses is indispensable, as it guides decisions regarding the professional responsible for the procedure, the selection of the appropriate dressing, and the monitoring of wound progression. When the NP is not applied in a systematic and properly documented manner, the clinical reasoning underlying these decisions may become weakened, compromising individualized care and the quality of the assistance provided[17].

In this context, the performance of the procedure by the nursing team requires active supervision by the nurse, understood not merely as oversight, but as a tool for improving the quality of care, centered on patient needs and the continuous enhancement of care practices[20]. In this regard, supervision plays a strategic role in coordinating the care process by establishing individualized plans and goals throughout the course of treatment[21].

It is important to emphasize that wound treatment extends beyond the dressing technique itself, requiring a comprehensive assessment of both the patient and the lesion to support clinical decision-making. This aspect becomes particularly relevant considering that wound care is often initiated in the UPA and subsequently continued at the referral hospital.

However, although decisions should be based on a comprehensive view of the needs of hospitalized patients, the high workload imposed on nurses forces them to adopt a prioritization logic, often described as "putting out fires," that is, dealing with multiple emergency tasks simultaneously[22]. Frequent interruptions in the work process highlight the unpredictability of activities and the intensity of the care environment, generating discontinuity and fragmentation of care[22].

The UPA, originally designed to provide medium-complexity urgent and emergency care with a maximum stay of 24 hours for clinical stabilization and care planning, has increasingly been used as a prolonged hospitalization setting due to the unavailability of beds in referral hospitals.

This extended stay compromises the quality of care, worsens patients' clinical conditions, and prevents timely access to appropriate settings for continuity of care[23].

Prolonged stays in UPAs, combined with precarious working conditions such as insufficient staffing, lack of protocols, and inadequate supplies, result in an increased risk of complications, longer hospitalization periods, and the development of comorbidities. The provision of safe and high-quality care requires adequate physical infrastructure, material resources, appropriate staffing levels with qualified professionals, and organization of care processes aligned with best practices[24].

The absence of standardized wound treatment protocols, combined with insufficient technical knowledge among some nurses, contributes to the adoption of divergent practices, thereby weakening the quality of care. This fragility becomes even more pronounced when activities that are exclusive responsibilities of nurses are delegated to nursing technicians without legal support or adequate technical competence.

Therefore, it is important to emphasize that, despite the structural and organizational limitations of UPAs, the NP must be carried out in a deliberate, systematic, and continuous manner, as normatively recommended, serving as a tool for organizing care, supporting clinical reasoning, and documenting the interventions performed[16].

In this study, the NP did not emerge as a central element in the participants' statements, which were primarily focused on the performance of dressing procedures, assignment of responsibilities for the procedure, and actions taken in response to complications. This focus may indicate that care is being delivered under a logic more centered on responding to the immediate demands of the service rather than through a systematized approach. The possible weakening of the NP may contribute to difficulties in monitoring hard-to-heal wounds[18].

Given this scenario, the need for implementing Continuing Health Education (CHE) emerges as a training process integrated into the work routine, in which learning occurs through the problematization of practice and the collective construction of knowledge[26]. CHE recognizes the work process as a pedagogical space, valuing critical inquiry, reflection on everyday challenges, and the shared development of solutions[27].

Thus, care provided to individuals with wounds hospitalized in UPAs is configured as a complex phenomenon, permeated by multiple factors such as overcrowding, intensification of work, physical and emotional exhaustion among professionals, noncompliance with legislation, among others, all of which directly impact the quality of care delivered.

Study Limitations

As a limitation of this study, the potential for social desirability bias should be highlighted, considering that participants may have provided responses more aligned with socially acceptable expectations, particularly because one of the researchers was a member of the nursing staff at the investigated UPA. Although all nurses from the unit participated, the findings reflect the specific context of the studied service, which limits their generalizability to other settings with different care dynamics.

Recommendations

In terms of contribution, the results of this study demonstrate that work overload in the UPA constitutes a significant challenge and an important barrier to the provision of safe and effective care. Furthermore, the findings reinforce the strategic importance of continuing education in the standardization of practices, such as wound treatment, promoting greater therapeutic effectiveness and improved clinical outcomes for patients.

CONCLUSION

This study made it possible to understand the care provided by nurses to individuals with wounds hospitalized in an Emergency Care Unit (UPA) while awaiting transfer to a referral hospital. The findings demonstrate that the prolonged stay of patients, resulting from weaknesses in the coordination of the Healthcare Network (RAS), alters the care profile of UPAs, which begin to assume functions similar to those of inpatient units without, however, having the structure and resources compatible with these care demands.

In this context, care provided to individuals with wounds occurs amid high healthcare demand, work overload, and organizational limitations, which hinder systematic wound assessment by nurses and favor the delegation of dressing procedures to the technical nursing staff. In addition, patient turnover and the intensity of the work environment make it difficult to monitor wound progression.

It can be concluded that nursing care provided to individuals with wounds in UPAs is strongly conditioned by the organization of the work process and by the structural limitations of these services. These findings highlight the need to strengthen coordination within the healthcare network, invest in continuing education, and improve nursing working conditions in order to enhance the care provided to individuals with wounds treated in Emergency Care Units.

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GRF: Project administration, Formal analysis, Conceptualization, Data curation, Writing – original draft, Writing – review and editing, Investigation, Methodology, Supervision, Validation, Visualization. MGA: Writing – original draft, Writing – review and editing, Investigation, Validation, Visualization. SMS: Formal analysis, Conceptualization, Data curation, Writing – original draft, Writing – review and editing, Methodology, Supervision, Validation, Visualization.
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